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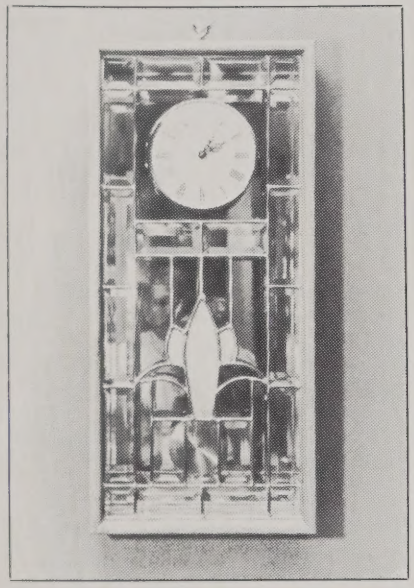

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THE HAMPDEN HIPPOCRAT

VOLUME XXXXIII NO. 5
AUGUST—SEPTEMBER 1987

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HAMPDEN DISTRICT MEDICAL SOCIETY 1987-1988 SEASON

DISTRICT MEETING

PLACE:	**CHEZ JOSEF** Shoemaker Lane, Agawam, MA
DATE:	Tuesday, September 22, 1987
BUSINESS MEETING:	6:00 p.m.
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m. Spouses are welcome!
SPEAKERS:	Representative Lee A. Daniels, House Minority Leader, Illinois General Assembly and Herbert Sohn, M.D. Urologist and Republican Candidate for Congress/Illinois
SUBJECTS:	Tort Reform in Illionis (Representative Daniels) and Physicians in the Political Arena (Dr. Sohn)

NOTE: If you must cancel your dinner reservation, please call the office before noon on September 22nd. If the cancellation is not made, you will be BILLED for your dinner.

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THE HAMPDEN HIPPOCRAT

AUGUST—SEPTEMBER 1987

VOLUME XXXXIII NO. 5

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT is published bi monthly.

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All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, MA 01109: Telephone: 736-0661.
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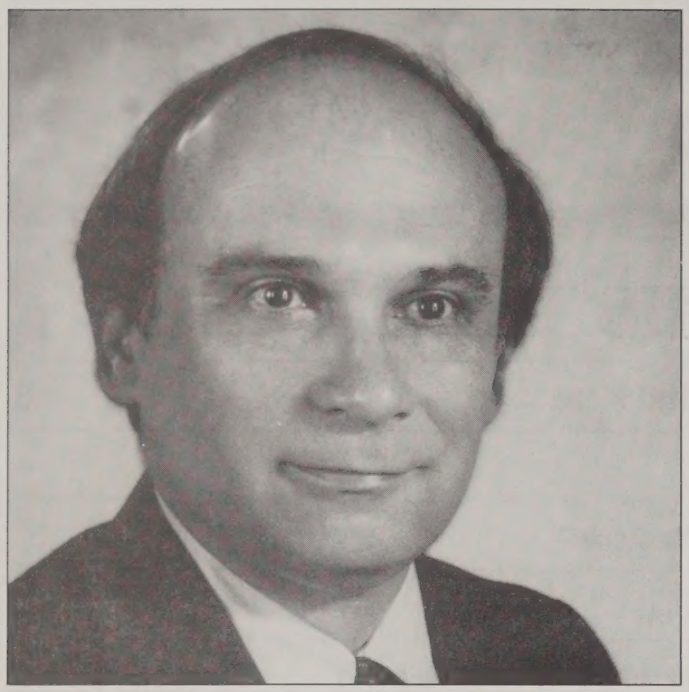
HDMS President's Message

American Greatness: An Oxymoron?



Gregory A. Slachta, M.D., President

American society is at the crossroads of its destiny. A great society arrives at that crossroad at some time in its existence. It develops its greatness through productivity, work effort, perspiration and reward of excellence. It rewards its scholars and creative talents with respect, due honor and appreciation. At some point, when a level of accomplishment and success has been achieved, it has an opportunity to rest on its laurels or advance on its abilities. America, I believe, is at the crossroads. Alas, I believe it has chosen to rest on its laurels and is failing to advance to the true greatness it can achieve.

It is evident to me in the field of health care, but I believe it is no less true in other professional disciplines; education, engineering, etc. Rather than questioning the stagnation, our leaders choose to politicize the failure. American stagnation, and non-competitiveness in the world market, has led to unfulfilled promises to our elderly and our frail. Congress chooses to explain the inability to fulfill the Medicare promise on the medical community rather than accept the responsibility. Truly, I see no great statesman in Washington. I see no leadership in Congress or in the White House. A true leader is willing to tell his constituency that times are bad and give direction, no matter how painful it is to solve the problem. Our Congress has a Social Security system that is destimed to failure within twenty-five years and they do nothing. Our Congress has a Medicare system that will go bankrupt within twenty-five years and they are in the process of expanding coverage to include catastrophic and drug coverage without the means to pay for it. They have not learned from the failure of 1964 Medicare cost estimates. Now, there is nothing wrong with expanding coverage. But to do so takes responsible people who feel it is appropriate to find a means to pay for it rather than to continue to borrow from future generations. The Congress would stand up and ask how many people want pizza? It is doubtful that less than 85% would want some. Leadership by consensus. But that is not leadership. That is not statesmanship. That is irresponsible politics. Congress for years worked on the principle of spend, tax, spend, tax. It now works on the principle of spend, borrow, spend, borrow. Some day our children may turn around and say, "Mom and Dad, I don't want to pay the bill."

The story that best expresses Congress and the budget

continued

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today is the one about the three hunters, who each year would charter a small plane and hunt caribou in a remote valley in the mountains of Canada. They would load up a small plane with guns, ammunition and provisions and the three men and pilot would fly over the snow capped mountains into a green lush valley. The pilot would leave the three hunters off for a week and return the following week to pick them up.

As he left them off he told them that they must bring back no more than one caribou because the plane could not carry any more. Off he flew. A week later he returned, swooping down over the snow covered mountains into the lush green valley. He approached the three hunters. There in front of each hunter was a caribou. This was too much for the pilot who began to shout and scream "Didn't I tell you, only one caribou for the three of you?"

"Well, yes" said one of the hunters, "but last year you said that and for twenty dollars you took us all. How about if we give you fifty dollars apiece this year?"

Well, they packed the three caribou and hunters and pilot and gear in the small plane. With caribou parts sticking out here, there and everywhere the creaky plane started down the runway. It got twenty feet off the ground and at the end of the runway crashed into the tops of the trees. Well, it wasn't going fast enough for anyone to be seriously injured but there were hunters and caribou hanging in the trees. One stunned hunter turned to another and asked where they were? The other looked around and said "Oh, we're about 150 yards farther from where we crashed last year."

No doubt Congress will continue to crash this year as it did last. It is beginning this year's crash with the budget reconciliation bill that will further cut hospital and physician reimbursement by two billion dollars (400 million from physicians). Only political activism by physicians and the elderly will blunt this effort. The sad thing is that it shouldn't be necessary. America's greatness, fostered and nurtured, should sustain quality accessible care for its people. It should be able to pay for quality providers. That will change the slumping applications to medical and nursing schools. It chooses not to do so. Hopefully, this year's crash will be only 150 yards from last year's crash. It will be closer, however, to the precipice of no return.

"It is time for a new generation of leadership, to cope with new problems and new opportunities. For there is a new world to be won"

John Fitzgerald Kennedy,
July 4, 1960 ■

Dr. Philip Stoddard is President of Mass. Society of Plastic Surgeons. **Dr. Paul Friedmann** is President of the Mass. Chapter of the American College of Surgeons. Our Appologies for these misprints in the last issue.

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The following essays were the winning entries in the recent "Pride in Medicine" essay contest. Congratulations to Drs. Glodt (Physician Catagory) and Dagincourt (Student Category. *The Editors*

The Letter

The Gray Haired Man and The Student walked along the beach. The man did most of the talking.

"There are many worlds out there." He spoke slowly and deliberately, stretching out both arms to encompass both land and sea. "Two appealed to me. One world is filled with cells that sprang from this ocean. It is a world branded with double helix bits that breathed immortality into all living things. It is bathed in cool logic and encompassed by numbers that extend to infinity." The Gray Haired Man paused to stare out over the water. He resumed his walking and his talking.

"Fire and ice, storm and tranquility engulf the second world. It is made of sadness and joy, hatred and love, raw greed and God-like humility. It is the world of people struggling for a Happy Day."

The Student interrupted. The voice was heavily flavored with impatience. "You began all this when I asked why you suggested I become a physician. Why?

"Because a physician lives in each of these worlds, tasting a little of each, never satiated with either one. Let me tell you a true tale to demonstate my point."

She had Rebel of the Sixties written on every feature of her unadorned face and unbrushed Afro. She sat as far from her mother as the small consultation room would allow.

"I'm not 'high on dope half the time', for God's sake, Mom. I'm not 'sleeping around with every jerk on the block'. And I don't 'spend all my day rockin' and rollin'."

The Mother recoiled under the blast, ran a nervous hand over a pale, thin cheek. She dabbed at her eyes with a tiny, wrinkled handkercheif and made sniffly noises. The Doctor sat behind his cluttered desk and spoke into the phone.

"I'll call back, Mrs. Browning. No interruptions, unless it's an emergency. Thanks." He replaced the receiver.

The street traffic worked its way through the rain smeared window but did little to dilute the pall of conflicting vibrations that filled the room. Mother spoke softly, slowly, trying to recover her poise.

"I told Barbara that if it weren't for you, doctor, she wouldn't be here. I'm sure you don't recall, doctor. You have so many patients. It was seventeen or eighteen years ago. For two years Joe and I had been trying to have a baby. Remember, you had Joe have a sperm count. No, of course you wouldn't remember. Anyway, he was O.K. It was me. Good Lord, I'm just gabbing and wasting your time."

"Go on," said the Doctor. "If it's on your mind, it's important."

"Thank you, doctor. I went to the gynecologist who said everything down below was normal. Then I came to you for the first time. You got me pregnant."

The doctor laughed. The Mother blushed. "You know what I mean," she stammered.

The laughter cleared the air. Barbara sat back and smiled.

Mother continued, "I told Barbara the story. That's when she agreed to see you. I'm sure you don't remember.

The Doctor remembered. Joe worked at GE heavy transformer. He'd just been promoted to foreman. They had purchased their first home. A baby was next. But no baby came. The thought of adoption left them cold. They wanted *their* baby, *their* family. Hope was waning when Mother came to The Doctor. Big words and lots of tests, she thought. But no baby. The Doctor listened.

He didn't hurry her. He really listened. That stuck in her mind. He listened. He was interested. He offered hope and she needed that more than anything. Even after eighteen years she had no difficulty recalling that fatigue, the trouble she had doing ordinary housework, the skipped period that gave them hope, the negative pregnancy tests that, once again, brought despair. Wonder of wonders, The Doctor did not say, as had her friends, "It's just nervousness. Get hold of yourself. Why don't you and Joe take a vacation."

She recalled how she spilled out all her symptoms. The Doctor probed for more. Tired. God she was tired. Her Hair. What a mess. Couldn't do a thing with it. She looked so old. That damn "Oil of Olay" was for the birds. She felt physically cold and, what was worse, sexually cold. Joe was patient and gentle. But a man is not made of wood.

The Doctor checked her. Thoroughly, no hurrying, just enough small talk to keep her relaxed. Then those wonderful words:

"I think I know why you can't conceive. The history, the slow pulse even when you are upset, the dry skin,

continued

that cold feeling, your reflexes all suggest an underactive thyroid. Easily corrected with a once a day pill."

Mother's spirits soared but crashed with a black thud when The Doctor said:

"We'll need a confimatory blood test."

Another test. Another wait. Another false hope. But the test did confirm. The little thyroid pill did work its magic. One year later, Barbara was born. Mother remembered. Some things you don't forget. Ever. No matter how many years. No matter how many patients. For Mrs. Colten it was the little slice of time that made life worth living. For The Doctor that spark that made Medicine worth practicing.

"There's nothing wrong with me, doctor," said Barbara, standing up and stretching. Her tight fitting jeans, the fulness of her breasts jutting through the sloppy, grey sweatshirt, and the full-of-youth blue eyes spelled out The Me Generation/The New Wave. "Mom thinks I'm on dope and sleep around. I'm not and I don't. My school grades stink. I admit that. I just don't see any point in grinding away. The thought of four years of college leaves me cold. They'll probably throw me out of the honors program. All A's last year. Flunking everything this year." She pulled out a pack of cigarettes. "Mind if I smoke?"

"Yes. I prefer no smoking in this office."

Barbara lit up. Testing, thought The Doctor. He said nothing. She took a long drag and exhaled the smoke slowly. "I didn't come here because of what you did for Mom. I recalled the night, about a year ago, when Dad had his coronary. Four in the morning and you were waiting in the emergency room. "That's our doctor," said Mom. OUR DOCTOR. Those words. The subsiding fear as you talked to us every ten or twenty minutes. He's in shock. It's touch and go. He's out of shock but the heart rhythm is screwed up. His pressure is up and he has normal rhythm. The cardiologist has arrived and says things look better. The intensive care unit and your talks to Mom and me in the waiting room. The unhurried explanations. The hope and optimism in your voice, Doctor. Dad's recovery. That's why I came. There's nothing wrong with me."

She took a last puff and snuffed out the cigarette on the bottom of her sneaker. Casually she shoved the butt into her pocket.

"I wonder if Barbara and I could talk alone?" The Doctor asked.

"Certainly, doctor." Mrs. Colten left.

The young lady and The Doctor talked for half an hour. The phone rang.

"Emergency room on line two, doctor."

"Got to go, Barbara. If I can help, please call. My grey hairs don't mean I've forgotten the problems of age seventeen."

The Doctor never saw Barbara again. Twelve years went by. His secretary brought in a letter marked "PERSONAL". The Doctor read it, reread it and smiled. It went as follows:

26 Gracey Terrace
Northampton, Mass.
May 5, 1985

Dear Doctor:

Several years ago you and I had a chat in your office. You had my Mom, upset by my deteriorating school work and teen age meandering, leave the room. We talked for some time. Perhaps half in jest, you said: "You're not being fair to us old guys, Barbara. We depend on you to carry the ball so we tottering oldsters can sit back and relax. We need you. The community needs you. the country and this fouled up world needs you. If you quit, the ball game is over. Think about it."

I guess I thought about it. Yesterday I was made associate professor in the English department here at Smith college. I thought of you and knew you'd like to know.

A long overdue thanks.
Affectionately,
Barbara Colten Newburg

The Doctor flipped off the light. It was a good ending to a full day. He shared Barbara's letter with his wife at the supper table. Her eyes moistened. "How wonderful. How absolutely wonderful. You steered her when she needed steering. And think of the ripple effect."

"The ripple effect?" queried The Doctor. "Yes", his wife continued. "Students she will influence. And they, in turn will influence their children, their students. The ripple effect."

She rose and kissed him lightly on the forehead. "I'm proud that you're a physician," she said.

The Doctor sipped his coffee slowly. "I've always thought of it in terms of joy rather than pride. A joy and a privilege. Sounds a little corny but that's how I feel. It's all in that letter. Problems, pride, joy and tears. Medicine, has it all."

The Grey Haired Man and his young friend shook hands. The Student smiled and said: "I'll think it over."

Herbert R. Glodt, M.D.

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Why Study Medicine?

Everyone is asking: "Why study medicine?" Or so it seems! I remember what my father, a surgeon, described as the reaction of his collegues when he announced that I was going to medical school. "What's he doing that for?" Then there's the admonishment of interns and residents to enjoy what free time there is because it will soon be eaten up by responsibilities of the wards. The attendings are concerned with DRG's, the malpractice crisis, and their diminishing control over the politics of medicine. More than once I've felt like taking liberties with the Simon & Garfunkel refrain: "Is the theatre (Private Practice) really dead?"

I have little experience in the practice of medicine, not counting the fact that I grew up with a father who practiced it. My experience has been solely as a student—this hardly qualifies me to comment on its vicissitudes. Have I been listening carefully enough to my elders? Physicians are men and women not usually given to hyperbole about what they do, and their reticent comments signifying satisfaction may have caught me unawares. Might I have missed the meaningful glance or gesture which would have informed the wiser observer of a deeper purpose? Did I read between the lines of the progress note to understand what the physicians knew but could not, or would not say? I suppose physicians cannot allow themselves to become too self-satisfied because the next patient may be another painful reminder of the limitations of their art.

A walk through the ward is like a visit to an Art Museum. Instead of a wizzened face immortalized by Rembrandt, the skeptical expression of my older patient haunts my memory at the end of the day. Does not the upward gaze of the young man who has AIDS remind me of the painting of St. Francis? I find muself confused by the facial expression of an expectant mother. Where before have I seen such earnest inquiry? I feel as if my work in the hospital is connected to timeless experiences whose meaning is no clearer today than they were when the masters painted. Sometimes I find it disconcerting, but never boring.

And what of the future? The world of medicine in front of me seems nothing like Rockwell's painting of the pediatrician holding his stethoscope to the little girl's doll. This doctor knows something about human nature which I wonder if I will ever know. He knows about people. He has their trust. They confide in him. He takes care of the young. I will take care of the old. If I care to take the time, perhaps I will have a chance to learn a lot from my patients, and what I learn may not only be medicine. If I am interested enough, a person will be waiting for me behind the lab values, and the progress notes, a person who has already raised a family, a person who knows what it is to lose a loved one or friend. I'd paint Rockwell's painting differently, but of course I would be painting for my time as he painted for his.

What I enjoy most about my collegues, students and teachers alike, is their collective love of learning. Some of them formalize it through research projects, while others make each clinical situation an opportunity to learn. If as a group we share nothing else, it is curiousity, and because our work involves people, and what makes them sick, we find ourselves addressing important questions. Asking questions sometimes produces answers, and these answers inevitably provoke more questions. Why does a kidney or heart fail? How quickly must an operation follow the presentation of an acute abdomen? Is this troubled individual competent to make decisions regarding discharge against medical advice? These dilemmas must be approached with calm, foresight, and compassion. Each situation challenges us to learn something from it, and to apply it to the next situation. Moreover, the information explosion pushes the physician to use his curiousity and learning skills optimally in order to translate the technical advances of a technical world into an intervention which has meaning for his patient. The physician holds the unique position of bridging the results of scientific inquiry to the day to day lives of his patients.

Ironically, in spite of ever increasing specialization, the physician must strive to widen his view of the world. People still ask me "Why study medicine?" I answer them. "because an M.D. degree is the liberal arts education of the 21st Century!"

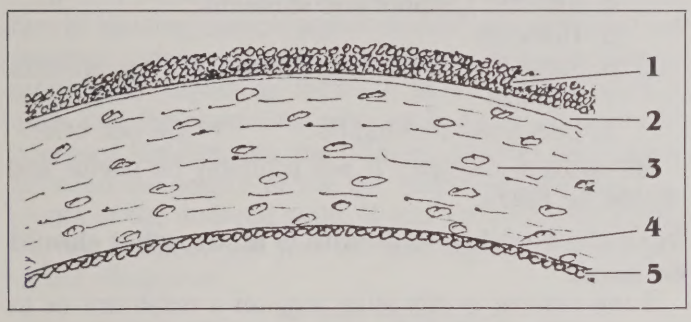
Paul Dagincourt

The Gift of Sight

I would like to heighten your awareness of the need for donations of human eyes to the New England Eye Bank. It was not many years ago that corneal transplantation was a somewhat exotic surgical procedure; sometimes even considered a newsworthy event. However, in the 1980's both need, frequency and success rate of corneal transplantation have increased dramatically. Unfortunately, such procedures require the donation of eyes by our deceased patients.

What is a Corneal Transplant?

The cornea is composed of five layers.



1. **Epithelial Cells** - a protective layer that keeps infectious agents out of the cornea and aids in its metabolism.
2. **Bowman's membrane** - a perfectly smooth surface that provides an optical surface upon which the epithelium adheres.
3. **Stroma** - perfectly clear layers of collagen fibers and keratocytes that make up 90% of the bulk of the cornea and maintain its shape and toughness.
4. **Descemet's membrane** - a thin, glassy, inert membrane separating stroma from #5.
5. **Endothelial cell layer** - a very delicate layer of cells with a very high metabolic rate; it acts as a pump constantly pumping water out of the corneal stroma to maintain its clarity.

In the corneal transplant a circular button, approximately 8 mm. in diameter is cut out of the 11 mm. cornea and replaced with a similar button cut out of donor cornea and sutured into place with 10.0 or 11.0 nylon under an operating microscope. Layers 2 through 5 are transplanted while the host's own epithelium covers the graft within a few days.

Who needs a Corneal Transplant?

Corneal transplantation helps eyes that become blind because of:

1. **Corneal scars** - These can be caused by trauma, burns, bacterial, viral, or fungal infections, or may be congenital. These often cause blind eyes in young active persons.
2. **Loss of the corneal spherical shape** - Keratoconus is a degenerative disease which strikes young adults and causes a thinning and bulging of the cornea totally disrupting its optical properties. It is often bilateral.
3. **Corneal Edema** - This is more a disease of the elderly and is due to malfunction of the endothelial cell layer. There is a broad spectrum of endothelial cell dystrophy. The most severe forms cause a primary decompensation and edema of the cornea. More commonly, a moderate degree of endothelial cell dystrophy is exacerbated by cataract surgery, glaucoma, or iritis It is often difficult to predict which cataract patient with concomitant endothelial disease will develop post-operative corneal endema. More and more these patients are advised to undergo a "triple procedure", where corneal transplant, a cataract extraction, and an intraocuar lens implant are all done in one procedure with a greater success rate and faster recovery than if done seperately.

Where do the Corneas come from?

Obviously they come from us; from the eyes of our deceased patients, our families, and ourselves. Nothing happens until, through death, human eyes are donated.

How are Corneas distributed?

The New England Eye Bank was founded in 1946 as a non-profit agency to distribute donated corneas throughout Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. About 400 corneal transplants are done a year in this area. Probably about 20 per year done in Hampden. The average patient waits about six months, but some as much as a year for their name to come up. The New England Eye Bank collects the donated eyes and keeps a list of surgeons and patients and attempts to distribute them in an even handed manner.

Who harvests the Eyes?

The New England Eye Bank has trained two technicians in Hampden to harvest the donated eyes. One surgical technician travels throughout the area while the other, an assistant in the pathology lab at Baystate Medical Center, harvests eyes at that institution. If they are unavailable, many ophthalmologists are willing to perform the harvesting service. Each hospital and nursing staff should have a protocol to follow when the need arises.

continued on next page

The Gift of Sight continued from previous page

Whose eyes are donated?

Some donors preregister with the New England Eye Bank or through a uniform donor card or through their driver's license. In other cases the family or guardian may authorize donation; however, at the time of bereavement they probably will not think of donation unless asked by you, their physician. Age is not a limiting factor in the usefulness of the donation. However, the following factors are:

Contraindications to transplant

A. Tissue which may represent a *health threatening* condition for the recipient or be contraindicated because of endothelial dysfunction:

1. AIDS
2. Death of unknown cause
3. Death from central nervous system disease of unknown etiology

** 4. Jakob-Creutzfeldt disease

5. Any case of dementia
6. ALS or amyotrophic lateral sclerosis, also known as motor neuron disease
7. Subacute sclerosing panencephalitis (SSPE)
8. Progressive multifocal leuconenephalopathy
9. Progressive supranuclear palsy or the Steele-Richardson-Olszewskui syndrome.
10. Cases of multiple sclerosis or septic neuritis
11. Cases of extrapyramidal disease, i.e. Parkinson's disease, that does not have a firm arteriosclerotic etiology
12. Known viral infection
13. Congenital rubella
14. Reyes syndrome
15. Subacute encephalitis, tytomegalovirus brain infection

** 16. Septicemia
** 17. Hepatitis
** 18. Rabies

19. Intrinsic eye disease - retinoblastoma, conjunctivitis, iritis, glaucoma, corneal disease, (e.g., keratoconus or pterygium) and malignant tumors of the anterior segment.
20. Blast form leukemia
21. Hodgkin's disease
22. Lymphosarcoma
23. Alzheimer's disease

B. Tissue which may require caution with regard to donor selection:

1. Parkinson's disease, that does not have a firm arteriosclerotic etiology
2. Amyotrophic lateral sclerosis
3. Jaundice, r/o leukemia
4. Chronic lymphocytic leukemia
5. Diabetes
6. Surgically induced eye abnormality, e.g. aphakia
7. Syphilis
8. Infectious meningitis

** Do not offer

Tissue from category B will probably be useful and should be taken.

Once the decision to donate is made, what should be done?

If the patient is still alive, e.g. on a respirator or in a coma, the eye should be protected from desiccation by using lubricating ointments and taping the lids closed. Upon death the New England Eye Bank should be notified, **(617) 523-7900.** If a technician is available, they will contact him/her. If not, the ophthalmologist on call will be asked to perform the enucleation. Time is of the essence. The eye should be removed within six hours of death. In addition to the eyes, blood will be taken for testing for AIDS. The enucleated eyes will be taken to the New England Eye Bank, often by Peter Pan Bus. Upon arrival the condition of the eyes will be inspected and if good, the corneas will be removed and placed in K-Sol, a special culture medium which maintains the corneas viability for up to a week, (perhaps longer). This time preservation is most important now that all donors must be tested for AIDS. Transport time and testing time often accounts for several days of delay.

continued

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Anatomical research, particularly in glaucoma, is dependent entirely on donated human eyes. Practice surgery by ophthalmology residents must begin with donated eyes. Surgical techniques are too precise and delicate to allow beginning with living eyes.

Of late, techniques have been developed to use rejected human corneas to make "living contact lenses". Layers 2 and 3 (Bowman's membrane and stroma) are frozen and lathed to a new optical shape (much like a contact lens) and grafted on the top or inside of the host cornea to change large refractive errors. These techniques are no longer on the horizon but are available now. But donated human corneal material is a prerequisite for the general dissemination of these advances.

At this point it must be perfectly clear that correction of blinding corneal ocular disease, eye research, and resident training, and many future refractive surgery techniques require an increase in donation of human eyes. You, the physicians who are in direct contact with bereaved families, are the primary contact and liaison between the source of the eye donations and the recipients of the restored sight. If you set a goal of acquiring one donation per year the shortage of donated eyes would disappear.

Terry D. Ryan, M.D.

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TOPIC:
"AIDS PATIENTS AND THE HEALTH PROVIDER"

MAIN SPEAKERS:
Robert J. Levine, M.D.,
Professor Yale Medical School and
Kathleen A. Nolan, M.D.,
Pediatrician, Hastings Center

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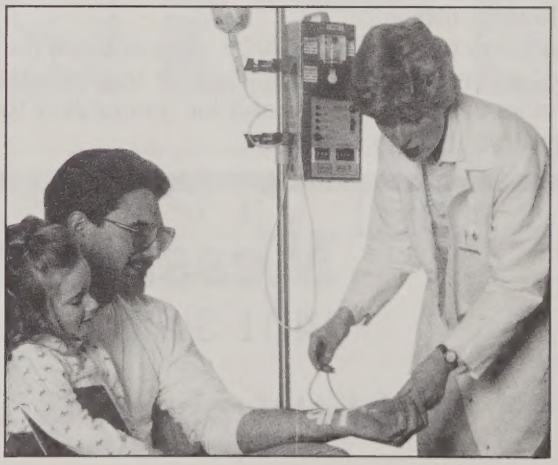

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Report of the 1987 Annual Meeting of the House of Delegates

CHICAGO JUNE 21-25, 1987

The AMA House of Delegates met in Chicago on June 21 through June 25, 1987. President, John J. Coury, Jr. M.D., issued five challenges to the profession aimed at improving the welfare of patients and physicians in this country. These include challenges to be active as community leaders; to relate to patients with understanding and openness; to be strong advocates of medicine; to be uncompromising in the practice of cost-effictive, quality medicine; and finally, to seek unity in the profession.

Some of the major issues considered at the meeting were:

I. AIDS

The prevention and control of AIDS easily dominated the discussion at this meeting and received widespread media attention.

The report of the meeting expressed an overriding concern that there be a judicious balance between the well-being of HIV-positive patients and the protection of the public health.

The expanded policy position directs AMA to monitor continuously and analyze developments in AIDS and update policy.

A major thrust of the report is that education must continue to be the major weapon in halting the spread of HIV infection. It was emphasized that physicians should assume the leadership role in educating themselves and the public, and that individuals of society must assume responsibility for being well-informed, and for actions that affect their own health and the health of others. It also stated the need for concerted and cooperative efforts by all members of the society in the fight against AIDS.

The House called for:

1. Mandatory testing for the AIDS virus in blood donors, organs, and other tissues intended for transplantation, for donors of semen or ova and for immigrants to the U.S. and for military personnel.

2. In addition, voluntary testing should be regularly provided for patients from areas of high incidence.

II. Foreign Medical Graduate Section

The house did *not* approve the establishment of a new Section for Foreign Medical Graduates which had been recommended by the Board.

III. AMA Finances

There will be no increase in dues in 1988, but will likely be required in 1989.

IV. Dispensing by Physicians

After much discussion it was RESOLVED, That the American Medical Association support the physician's right to dispense drugs and devices when it is in the best interest of the patient and consistent with AMA's ethical guidelines.

V. Health Policy Agenda for the American People

Culminating five years of effort to reexamine the basic values upon which the health care system is based, the House considered 195 recommendations of the Health Policy Agenda for the American People.

The House adopted the bulk of the HPA recommendations as policy. A few were rejected. A final version containing the AMA House actions will be available in August.

VI. PRO's

The difficulties physicians are having with PRO's continue to impact upon the House of Delegates through the introduction of a large number of resolutions.

There was an expression of the AMA's view that PRO's should be oriented toward assuring quality to non-punitive, educational approaches.

There are a large number of recommendations aimed at attempting to protect the Medicare beneficiaries and protect the physicians who are being sanctioned were expressed. The specific problems they attempted to address are too numerous to enumerate.

continued

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VII. Physician DRG's

The House reiterated AMA's strong opposition to include any physician under the DRG program by recommending that the AMA:

1. continue its vigorous opposition to any proposal that would reimburse physicians according to diagnosis related groups (DRG's)

2. and to continue its oppositon to the discriminatory proposal by the U.S. Office of Management and Budget to include compensation of radiologists, anesthesiologists and pathologists under in-hospital DRG's.

VIII. Omnibus Budget Reconciliation Act of 1986

The House considered several resolutions that addressed problems physicians are experiencing with OBRA and called on the AMA to:

1. use all appropriate means to rescind those recently enacted regulations and statutes which unfairly discriminate against health care providers;

2. request Congress to return to the original intent of the Medicare Law (Title XVIII).

IX. MAAC Regulations

The House considered a report from the Council on Medical Service and several resolutions dealing with problems associated with Medicare reimbursement and the discrepancies in Maximum Allowable Charge calculations.

The House adopted policy calling on the AMA to:

1. continue to seek judicial, legislative and regulatory changes that will eliminate the medicare maximum allowable actual charge (MAAC) regulations for participating physicians.

2. seek to assure, in the meantime, that all Medicare fiscal intermediaries send to non participating physicians adequate information for calculating MAAC levels.

3. support any individual component society's legal efforts to prevent passage or overturn any state law that restricts the right of physicians to contract for services rendered to their patients under certain conditions.

X. Scientific Informational Reports

Although no House action was required, the delegates received a record number of information reports from the Council on Scientific Affairs.

XI. Tobacco

The House of Delegates took several actions to augment the AMA's continuing program in opposition to the use of tobacco products:

1. Recommend that the Federal Aviation Administration establish regulations to ban smoking on all commercial aircraft.

2. Develop model legislation to improve enforcement of laws restricting children's access to tobacco and

3. Advised a variety of education efforts to diminish the use of tobacco ■

Summarized by
Terry D. Ryan, M.D.

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The Omnibus Physician Reimbursement Act of 1988

After reviewing the report on OBRA in the last issue of the Hippocrat, our roving cynic has filed this report on Massachusetts' own brand of legislation.

The Editors

In a landmark decision, the Massachusetts Supreme Court upheld the Omnibus Physician Reimbursement Act of 1988, which had been passed by the state legislature and endorsed by Medicare and Blue Shield, but had been contested by the Massachusetts Medical Society.

The OPRA as it has come to be known, contains several controversial provisions, including:

A) Physicians must submit full handwritten histories and physical examination findings with a detailed explanation of why a particular action (blood test, chest x-ray, etc.) was undertaken, before any reimbursement is considered. Although many physicians have suggested that this requirement will result in an enormous waste of time, Senator Mike O'Malley, (D-Boston) the author of the bill, pointed out that despite previous efforts at cost containment, unnecessary tests continue to be ordered. "More than half the chest x-rays ordered are entirely normal, " said the senator, an expert in health care financing, "and the same goes for most other tests. A test with a normal result is prima facie an unnecessary test."

B) Before any reimbursement for a surgical procedure is considered, the case and justification for surgery must be reviewed and approved by a physician reviewer from MassPro (the peer review organization responsible for quality assurance and for cost containment). "The turn-around time right now is somewhat long," admitted D.W. Snigger, M.D., the director of MassPro. "Six months is indeed a bit long to wait for an appendectomy. However, more and more physicians, particularly obstetricians, neurosurgeons, and orthopedists, are signing up to be physician reviewers as they leave their active surgical practices. Also, many older physicians are becoming full-time reviewers rather than continuing in part-time practice. We anticipate that by 1988, more than half the physicians in the state will be full time peer review doctors."

C) If a patient expires while under a physician's care, no reimbursement will be provided, and the physician will have his license suspended until reviewed by the state board of registration. "Physicians are accustomed to burying their mistakes," said Representative Alphonse M. Slade, D-Gardner. "If they are in the business of saving lives, then a lost life is obviously an error in judgement and a warning signal to society. I don't see anything wrong with this provision.

D) Physicians must prescribe the cheapest drug. Until recently, physicians had the option of prescribing a drug, and the pharmacist would fill the prescription with the cheapest substitute. The new ruling requires that the cheapest available drug be prescribed, regardless of the "class". In practical terms, this means aspirin. "I don't see what the controversy is all about," commented Edward M. Hardcore, the head of the Medicare office in Boston. "Medicine is Medicine. People are going to die sooner or later anyway. The new rule will save Medicare several billion dollars a year. We can't go on subsidizing a health care industry which spends most of its resources on the elderly, who are not contributing to society in any meaningful way."

E) Before being allowed to practice, physicians must pay malpractice premiums for 24 years; and physicians in active practice must be paid up for 16 years. The fact that they are "paid up" now does not protect them from retroactive and prospective rate hikes, and even if they expire, their estates and decendents are liable for future adjustments. Etaoin Sherdlu, the director of the Massachusetts Joint Underwriters, defended this policy. "Last year, the Joint Underwriters took in $1,980,000,000 and paid out $323,567,435. The previous year, premium payments came to $1,643,725,000 and we paid out $267,987,342. At this rate, the Joint Underwriters will be financially insolvent by 2387, only 300 years from now."

F) All physicians' reimbursement must be collected between the hours of 10:00 AM and 2:00 PM, in person, at Blue Shield/Medicare payment office in Boston, on the first Thursday of each month. This provision will save substantial amounts in terms of postage, pager, and personnel.

G) All physicians holding licenses to practice must be participants in Medicare and Blue Shield.

H) Physicians cannot give up their licenses to practice without a hearing.

I) At least one child of each physician holding a license to practice must attend a medical school in Massachusetts. Failure to do so will result in a mandatory

continued

prison sentence for the physician of 5 years. A physician without children must pay the cost of eight years of medical school tuition.

J) Any graduate of a Massachusetts Medical School will receive a license to practice medicine with his/her diploma.

K) It will be considered a felony punishable by five years in prison for a physician who holds a Massachusetts license to leave the state. This is retroactive to 1980.

"People have worried that our regulations might drive physicians away from Massachusetts," said The Governor, "but I think these last five provisions should reassure them that they will always have medical care." When asked whether he thought some of these provisions violated civil rights, The Governor said, "In my opinion, this is a situation in which the civil rights of the sick come first."

M. Gardley Sprockett, M.D., the president of the Massachusetts Medical Society, remarked that the OPRA is not ideal, and that she is hopeful that modifications can be made over the next several years. "I think we all recognize that some degree of regulation is necessary," she said, "but some of the provisions in the OPRA seem to me to be poorly conceived. But then, I could be wrong. In fact, maybe I should read the bill again. Hey, I'm probably wrong, you know? And besides, we did manage to reduce the mandatory prison terms from 20 years to five years, so we are willing for now to accept this compromise bill."

Snavely S. Reptile, the president of the Massachusetts Trial Lawyers Association, hailed the OPRA. "Physicians must realize that society will no longer tolerate their parasitizing those who are sick, disadvantaged, and old," he told the graduating class at Harvard Law. "Furthermore", he added, "We must continue to widen the definition of malpractice. Only in this way can we protect society from incompetence". Reptile has been advocating that anyone holding a Massachusetts license to practice medicine should be considered a priori incompetent if brought to trial. "The state is exceedingly generous in allowing physicians to practice on its citizens," he argued in a recent case in which the plaintiff was awarded $28,000,000. "But if you need practice, and something you do goes wrong, then it's obvious that you didn't practice long enough, and should have left the patient alone." ■

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Welcome New Members

Josephine Scottodicarlo, M.D.
305 Bicentennial Highway
Springfield, MA 01118

BORN:	April 18, 1956
PREMED:	Fordham Univ. Bronx N.Y.
MEDICAL:	Albany Medical College
INTERNSHIP:	Albany Medical Center
RESIDENCY:	Albany Medical Center
SPECIALTY:	Pediatrics

Thomas E. Mathews, M.D.
1515 Allen Street
Springfield, MA 01118

BORN:	February 24, 1946
PREMED:	Boston College
MEDICAL:	University of Conn.
INTERNSHIP:	Hartford Hospital
RESIDENCY:	Hartford Hospital
SPECIALTY:	Emergency Medicine

George D. Mitchell, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN:	February 28, 1954
PREMED:	City College of New York
MEDICAL:	New York University
INTERNSHIP:	UCLA Hospital
RESIDENCY:	UCLA Hospital
FELLOWSHIP:	Cardiology, UCLA Hospital
SPECIALTY:	Cardiology

Larry D. Robbins, D.O.
759 Chestnut Street
Springfield, MA 01199

BORN:	August 30, 1952
PREMED:	Boston University
MEDICAL:	Kirksville College of Osteopathic Medicine
INTERNSHIP:	Osteopathic Hospital of Maine
RESIDENCY:	Baystate Medical Center
FELLOWSHIP:	Baystate Medical Center
SPECIALTY:	Anesthesiology

continued

Visiting Nurse Association of Springfield, Inc.

Aids/Arc Support and Volunteer Services Program

On January 5, 1987, Governor Michael Dukakis announced the award of a state grant to the Visiting Nurse Association of Springfield (VNAS). The VNAS was one of eight home health care agencies around the state funded by the Massachusetts Department of Public Health to provide a specialized program to patients and families affected by Acquired Immune Deficiency Syndrome (AIDS).

The program which was designed by the VNAS, creatively offers case management, patient advocacy, education, direct care, and counseling to AIDS patients and their families. A full-time Nurse Case Manager coordinates the interdisciplinary service team offered by the program which includes: rehabilitation, therapists, a medical social worker, pastoral caregiver, nutritionist, bilingual outreach worker, AIDS/ARC support volunteers and specifically-trained home health aides. As part of the program, the Nurse Case Manager is also available as a consultant to other certified home care agencies in Hampden, Hampshire and Franklin counties.

The VNAS program, the first of its kind in the Commonwealth, will give patients and families stricken by the devastating illness an extra measure of support. The continuum of care facilitated by the program will help patients stay at home longer and assist in preventing unnecesary hospitalizations during the earlier stages of the disease.

It is the program's ultimate goal to sustain the family unit and ease its suffering from the AIDS virus through the consistent involvement of an interdisciplinary program team.

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Springfield, MA 01103

BORN: April 8, 1926
PREMED: Harvard
MEDICAL: Harvard
INTERNSHIP: Walter Reed Hospital
RESIDENCY: St. Louis Maternity N.Y. Living-In Hospital
SPECIALTY: OB/GYN

Robert J. Dachs, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN: February 14, 1959
PREMED: Middlebury College, VT
MEDICAL: New York Med. College
INTERNSHIP: Baystate Medical Center
RESIDENCY: Baystate Medical Center
SPECIALTY: Surgery
RESIDENT:

Karen L. Hathaway, M.D.
759 Chestnut Street
Springfield, MA 01199

BORN: August 4, 1960
PREMED: Grinell College
MEDICAL: St. George's University New York Medical College
INTERNSHIP: Baystate Medical Center
SPECIALTY: Pediatrics
RESIDENT:

Robert E. Primeau, M.D.
Dept. of Pediatrics
759 Chestnut Street
Springfield, MA 01199

BORN: November 28, 1961
PREMED: Vanderbilt Univ. TN
MEDICAL: Baylor College of Medicine
INTERNSHIP: Baystate Medical Center
RESIDENCY: Baystate Medical Center
SPECIALTY: Pediatrics
RESIDENT:

George M. Powell, M.D.
63 Harriet Street
Springfield, MA 01107

BORN: July 18, 1949
PREMED: John Hopkins Univ. MD
MEDICAL: Univ. of Ill. College of Med.
INTERNSHIP: Baystate Medical Center
RESIDENCY: Baystate Medical Center
SPECIALTY: Anesthesiology
RESIDENT:

Christopher H. Strayhorn, M.D.
87 Elliot Street #4A
Springfield, MA 01105

BORN: November 5, 1955
PREMED: University of Texas
MEDICAL: Baylor College of Medicine
INTERNSHIP: Baystate Medical Center
SPECIALTY: Pediatrics
RESIDENT:

Mark A. Jackowitz, M.D.
300 Stafford Street
Springfield, MA 01104

BORN: December 14, 1956
PREMED: Clark University
MEDICAL: University of Mass. Medical School
INTERNSHIP: St. Joseph Hospital, Colorado
RESIDENCY: University of Colorado Health Sciences Center
SPECIALTY: Ophthalmology

Inder V. Malhotra, M.D.
330 East Columbus Avenue
Springfield, MA 01105

BORN: May 22, 1930
PREMED: D.A.V. College, Ambala
MEDICAL: S.C.B. Medical College, India
INTERNSHIP: Irwin Hospital, New Delphi
RESIDENCY: Beth Isreal Hospital
SPECIALTY: Anesthesiology

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"Some physicians respond to this request by sending a photocopy of their consultation or operation note under the assumption that this comprises a medical opinion in regard to their patient's legal claim. They also send a bill as if such an opinion were being rendered. Photocopies of consultation notes and operation notes can be obtained from the hospital for a nominal charge, and chances are the lawyer already has these reports.

"The attorney is probably seeking an opinion from the physician about the relation of an accident to the subsequent injuries, the final diagnosis and the prognosis. These items should be specified in the attorney's letter, and should be addressed specifically by the physician. The physician may then charge a reasonable fee for this effort. He should keep in mind however that the fee he charges is billed directly to his patient and is not paid by the lawyer." ■

Lester Frank, M.D., Chairman
Medico-Legal Committee

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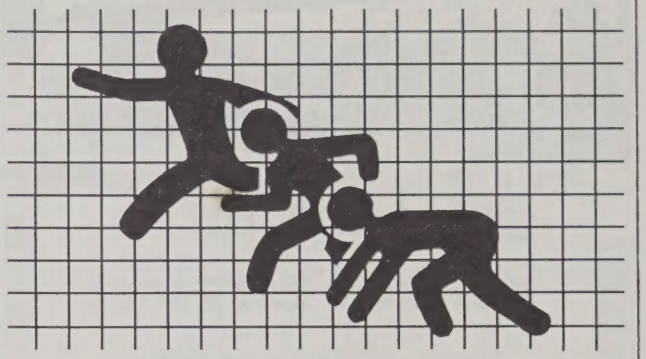

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It is imperative that we become used to communicating with our key members on issues vital to medicine.

Gregory A. Slachta, M.D.
President

MISCELLANEOUS INFORMATION:

100th Congress, First Session

SENATE: 54 Democrats, 46 Republicans
HOUSE: 258 Democrats, 177 Republicans

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To phone Senate offices directly, dial 224 and the four-digit extension shown in this directory opposite the Senator's name.

To reach a Representative, dial 225 plus the extension number listed opposite the name.

Some offices will change during this session. However, telephone numbers will not change. Check for proper office number by telephone prior to visiting a Member.

If calling from within a Senate office building, dial 4, and then the extension. From a House office building, dial 5 and the extension.

WHEN WRITING, these addresses and salutations are suggested:

The Honorable John Doe
The United States Senate
Washington, DC 20510

Dear Senator Doe:

The Honorable John Doe
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Doe:

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John F. Kerry (D) SR-362 2742

Representatives

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2. Edward P. Boland (D) 2426-RHOB 5601
3. Joseph D. Early (D) 2349-RHOB 6101
4. Barney Frank (D) ..... 1030 LHOB 5931
5. Chester G. Atkins (D) 504-CHOB 3411
6. Nicholas Mavroules (D) 2432-RHOB 8020
7. Edward J. Markey (D) 2133-RHOB 2836
8. Joseph P. Kennedy, II (D) ... 1631-LHOB 5111
9. Joe Moakley (D) 221-CHOB 8273
10. Gerry E. Studds (D) 1501-LHOB 3111
11. Brian J. Donnelly (D) 438-CHOB 3215

Sen. Edward M. Kennedy (D) (David Nexon), SR113, 224-4543
Sen. John F. Kerry (D) (Nancy Smith), SR362, 224-2742
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Cong. Edward P. Boland (D-Springfield, MA-2) (Ellen Philbin), 2426 RHOB, 225-5601
Cong. Joseph Early (D-Worcester, MA-3) (Jan Oliver), 2349 RHOB, 225-6101
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continued on next page

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